

**CANCER DRUG REPOSITORY PROGRAM  
NOTICE OF PARTICIPATION OR WITHDRAWAL**

Completion of this form meets the notification requirement for participation in, or withdrawal from, the Cancer Drug Repository Program under KSA 65-1664 et seq. Complete and submit this form to the following address. Questions about completing this form may be directed to (785) 296-4056 the Board's web-site [www.kansas.gov/pharmacy](http://www.kansas.gov/pharmacy), or faxed to (785) 296-8420.

**NOTICE OF PARTICIPATION  
PHARMACY ENTITY**

A pharmacy or medical facility may fully participate in the cancer drug repository program by accepting, storing and dispensing donated drugs or may limit its participation to only accepting and storing donated drugs. Check one of the following:

☐ Full Participation (Will dispense drugs)

☐ Partial Participation (Will NOT dispense drugs.)

Name-Pharmacy/ Entity		Telephone Number	
Address			
City	State	Zip Code	
Name-Pharmacist or Designee		Telephone Number	

I certify that the above named facility is licensed in the State of Kansas and is in compliance with all State and Federal laws and administrative rules.

SIGNATURE-Pharmacist or Designee	Date Signed
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**NOTICE OF WITHDRAWAL  
PHARMACY ENTITY**

Name-Pharmacy Entity		Telephone Number	
Address			
City	State	Zip Code	
As of (enter date) ____ - ____ - _____, the pharmacy/entity identified above, will no longer be participating in the Cancer Drug Repository Program.			
SIGNATURE-Pharmacist or Designee		Date Signed	